CONFIDENTIAL EMPLOYEE DATA

Company Name:		Date:	

NAME	SEX	CLASS	COVERAGE *FAMILY* *SINGLE* *OR* *WAIVED*	DATE OF BIRTH D	M	Y	EARNINGS ANNUAL [] MONTHLY [] WEEKLY [] HOURLY [] Hrs. per Week _____	OCCUPATION	DATE OF EMPLOYMENT D	M	Y	PROV OF RES.

Thank you for your interest in Employee Benefits with *Svab Insurance Inc.*

To obtain a quote, the following is required:

- ☐ Please complete the above employee data

If your company currently has benefits, the following is also required:

- ☐ Claims experience for the last two years
- ☐ A copy of your employee benefits booklet(s)
- ☐ Your most recent billing statement

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